COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

March 5, 2019
9:30 A.M.
Department for Medicaid Services
Commissioner's Conference Room
275 East Main Street
Frankfort, Kentucky

APPEARANCES

Suzanne Francis
CHAIR

Christopher Betz
Cynthia J. Gray
Paula Miller
Robert Warford
(appearing telephonically)
TAC MEMBERS

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Carol Steckel
Sharley Hughes
MEDICAID SERVICES

Mark Glasper
Executive Director
KY PHARMACISTS ASSOCIATION

Chris Palutis
KY PHARMACISTS ASSOCIATION

Carrie Armstrong
PASSPORT

Andrew Rudd
ANTHEM

Cathy Stephens
Joe Vennari
HUMANA-CARESOURCE

Thea Rogers
Ayonna Tolbert
WELLCARE

April Cox
AETNA BETTER HEALTH

Devin Freels
Emily Conner
PHARMACY STUDENTS

Chris Quenelle
PASSPORT PHARMACY RESIDENT

Candace McQueen
WELLCARE STUDENT

AGENDA

1. Call to Order, Welcome & Introductions

2. Approval of Minutes/Report from the January 8, 2019 PTAC meeting

3. Additional Discussion Topics/Reports/ Action Items
   * Roundtable report out on current state of affairs
   * Department of Medicaid
     - Options for pharmacy immunization coverage via prescription for children <9
     - Update on 1115 Waiver and implications for pharmacies and providers
     - Senate Bill 5 data report release update
   * Aetna Better Health of Kentucky
   * Anthem Blue Cross Blue Shield
   * Humana-CareSource
   * WellCare of Kentucky
   * PTAC Committee members

4. Follow-up on previous agenda items
   * Potential pilot programs to improve outcomes
   * Improving quality of care by leveraging pharmacists in Kentucky
   * Pharmacists as providers

5. New Business/Take-aways

6. Reports and recommendations from the PTAC to the MAC

7. Other Business

8. PTAC member nominations from KPhA

9. Next Steps
   * Next MAC meeting - March 25, 2019
   * Next PTAC meeting - May 21, 2019

10. Adjourn

DR. FRANCIS: We will go ahead and get started here. It's 9:32. So, let's go ahead and introduce ourselves.

(INTRODUCTIONS)

COMMISSIONER STECKEL: If any of the residents or students would like to do an internship at Medicaid, we would love to have them. Just an FYI.

DR. FRANCIS: I'm sure that Sullivan or UK would be able to work with that.

COMMISSIONER STECKEL: In all seriousness, we would love that. So, if we could just get together and talk about it, we would love to do it.

And Jessin Joseph, our Pharm.D pharmacist, is in class today, unfortunately, but that will be ending soon and he will be able to be at these meetings in the future.

DR. FRANCIS: Okay, and Jessin probably could work with the University of Kentucky to set up we call them an API experience and I'm sure Chris could do that, too.

COMMISSIONER STECKEL: That's excellent.

DR. FRANCIS: Okay. So, first

I wanted to go over - I don't think you have a printed copy but everyone was emailed the January 8th minutes and report to the MAC. I have them pulled up here if there are any questions but does anyone have any additions or a motion for approval?

MS. GRAY: I make a motion to approve.

MS. MILLER: I'll second.

DR. FRANCIS: So, Cindy and Paula motioned and seconded for the approval of the January 8th minutes.

So, now I guess we wanted to get into there's been a lot of updates in the last two months, I think, not to put you on the spot, Commissioner.

We usually go through current state of affairs, and I know that there's been a lot happening with the Department. So, I thought we'd give you a chance to just update what you feel is most relevant for the Pharmacy TAC, and, then, if we have any questions, we can add to that.

COMMISSIONER STECKEL: Okay. Wonderful, and most of it is things that you have identified already.

I'll start with the SB 5 data

report. We did meet with both the MCOs and the independent pharmacists, many of you in this room before the release of the report. And, then, we started having meetings with legislators and there's been one hearing before one of the legislative committees. And I would tell you which one it was if I could remember but we've been in full-blown legislative mode lately.

MS. HUGHES: I remember it but I can't----

COMMISSIONER STECKEL: Banking or, no, Revenue----

MS. HUGHES: Appropriations and Revenue I think is what it was.

COMMISSIONER STECKEL: Yes, but the bottom line is it went very, very well. They were very receptive. I think - and this may be my wishful thinking - but I think they were pleased with the depth of the data, even though it was just the beginning of what we're looking to do.

So, we're now moving into stage two and that's implementing the recommendations that are in the report and then looking at some other issues.

One of the things I'd like to

bring up to this group and ask your help for is the issue of the DIR's, the post point-of-sale adjustments. We need some help understanding those better because I know there have been several pharmacies that we've gotten notice lately that are closing and they've attributed it to those adjustments and we recognize it as a problem, and as you saw in our recommendations, we'd like to eliminate them.

Here is the ask of you all. We would like to - and Jessin and Doug Oiler will be the two that would do this - we would like to sit down with independent pharmacists and actually go through not your records but go through I guess your records and look at those and see what they are and be able to, in all confidentiality - we would keep it confidential - but to better understand the scope of those post point-of-sale adjustments. How do they relate back to the contracts, how do they make those adjustments?

We think we've got a good idea, thanks to you all, but we'd like to delve deeper into that so that when we implement the restriction, we're trying to close off all the right doors because, as you all know and live and breathe, the PBM's are

going to think of some other thing to call it than what they originally were supposed to be calling it.

DR. FRANCIS: Would you like me to put together a meeting with a representative of that or would you like KPhA to----

COMMISSIONER STECKEL: I think probably KPhA and it would be one-on-one because we really do want to honor the confidentiality and the proprietary nature.

Now, if someone doesn't mind us releasing that information, then, I think it's illustrative, but for us, we just need to know more. We need to understand it better in order to both implement the recommendation and to be aware of how we can----

MR. CLASPER: I was going to say, we have several members who would be more than happy to do that.

MS. HUGHES: I think you've got a volunteer.

MR. PALUTIS: I sent Jessin a bunch of information when he had requested out to one of our meetings and it listed all kinds of fees that come to us on the back end, and I would be more than happy to have him at my pharmacy. Now, I obviously

am not going to be able to show him patient-specific stuff but there is so many----

COMMISSIONER STECKEL: Sure. Well, actually, if they're Medicaid patients, you can.

MR. PALUTIS: Well, correct.

COMMISSIONER STECKEL: But I understand.

MR. PALUTIS: Right, correct, but there are reporting systems that we have that show us these fees. And, unfortunately, the PBM's are so - I'm trying to think of a politically correct word to use - they've very savvy in how they send these fees down, and Jessin will understand what I mean when I show him what we get to look at.

I can explain to you what a generic effective rate is and it's a very, very convoluted way to kind of pay somebody for their services. I can do that if you want or I can just explain it to Jessin when we meet and I'd be more than happy to one-on-one.

But essentially we get paid a point-of-sale based on MAC, or even for a generic drug, a lot of times with generic drugs, when they first get released, they don't have a MAC, so, we get

reimbursed off of AWP or MAC for a generic product.

Let's just say we fill that prescription in February. At the end of the year, the PBM says, well, you were not on a MAC fee schedule. You're on a generic effective rate schedule which means we're going to peanut butter spread your reimbursement with your pharmacy with all of your plans with all the other PSAO pharmacies and bring everybody down to an AWP minus a certain percent.

And, so, they don't even come back to us and say this prescription number costs you this much money for a generic effective rate. They just say you owe us money and we're going to take it out of your future reimbursement. That's one piece.

Another piece, now, the DIR fees and all those other things, my understanding is that they apply to Medicare claims.

So, that really doesn't affect Medicaid, but it is our understanding that we have found out recently that a lot of our contracts, Caremark in particular, has been on generic effective rate for quite some time.

And, so, you don't see all those back-end fees. And I'll show Jessin where they

show up and they're substantial.

COMMISSIONER STECKEL: Okay. And that's what we need to understand better. We understand the concept and are able to explain it very similar to how you did, but to really understand it in detail and be able to - and I would say this if they were in the room, if there are any PBM's in the room, but it's just like a lot of other providers.

We have to make sure when we squeeze the balloon, we're watching it pop up here. So, the more we understand it, plus this is one of the issues we identified, if not the number one issue, very close to it.

And, so, we want to make sure before we rush into what we think is the solution, that we completely, fully understand the scope of it and understand at your level what we're talking about. So, it would be extremely helpful.

MR. PALUTIS: Right. I would be happy to do it.

One thing I have to confirm first is that the GER calculations are already completed. Last we checked, we've been told that they haven't been finalized yet for 2018.

COMMISSIONER STECKEL: Okay.

MR. PALUTIS: Now, as you can imagine, we're already into 2019. We don't even know if we're going to owe money, get more money. We kind of just, you know, are kind of like this, but I'll try to find out as best I can because, then, that will substantially change even what is already pretty substantial fees taken out of the back end.

COMMISSIONER STECKEL: Perfect.

MR. CLASPER: Commissioner Steckel, roughly how many members would you like to talk to?

COMMISSIONER STECKEL: I would say five'ish. Let's do that and then see if they need more. And we may split them up where Jessin does some and Doug does others.

DR. FRANCIS: I thank you for that because, as I was speaking with Paula, we in Northern Kentucky recently had a pharmacy close Thursday and it's exactly the DIR and the generic effective rate is exactly what we were discussing.

So, I think we owe it to our Commonwealth to really understand that better, not just for the business of pharmacies but for patient health.

I know many people that have

reached out to me going where should I go, where should I get my medicine and things like that. So, I appreciate that.

MR. PALUTIS: And I agree. It's not just about saving independent pharmacies. It's about the Commonwealth's money and if the PBM is taking this money back, is it flowing back to Medicaid?

COMMISSIONER STECKEL: Well, and that's the other number one issue. So, these are the two critical issues. There are eight recommendations, but the pass-thru versus spread pricing is the first issue and, then, the back-end post-payment point-of-sale adjustments.

I am all for contracts that do value-based purchasing. I'm all for incentive-based contracts, but the gotcha garbage is not going to fly.

And you all know how powerful the PBM's are and how many lawyers they have. Like I said, I've dealt with more lawyers than statisticians on this report.

So, I want to make sure we have all of our ducks in the row, that we are as knowledgeable as we can be. And, then, with the

support of the Association and the independent pharmacists or pharmacy, not just the independent pharmacists, then, I think we'll make it through but it helps us to be very informed in this area.

MS. HUGHES: Just one thing to help Terri. I know she knows the TAC members by their name tags but everyone else, if you could give her your name when you start until she gets to know everybody because it's her first meeting.

COMMISSIONER STECKEL: So, the SB 5, we will continue working on this issue and it will evolve. We will continue to I hope get more - not I hope - we will get more sophisticated on data collection.

We are using that report to inform what will go into our contract and the RFP for the new managed care organizations.

One of the things with the managed care organizations that we're having to pay attention to is that most of them, if not all of them, are looking at this PBM issue, rightfully so, but bringing it in-house.

And in some cases, they've said they're bringing it in-house but it's in collaboration with an existing PBM. In some cases,

it's bringing it in-house, but we're trying to make sure we stay at least equal to the knowledge about what does that mean? If an MCO brings a PBM in-house, is it more or less transparent? Do the business practices change?

We don't know the answer to those, but we've put that on the table as something that we've got to be sensitive to, aware of and continuing to monitor. So, more to come on SB 5. Any questions on SB 5?

DR. WARFORD: Yes, I have a question. This is Bob on the telephone. I wasn't able to make it today but I'm a PTAC Board member.

So, what is the State's response to WellCare not turning in any data according to SB 5?

COMMISSIONER STECKEL: WellCare did turn in data. The reason you see the zeros on there is that by doing pass-thru reimbursement, they, in essence, they pay the PBM their administrative cost for what they are contracted to provide for WellCare and, then, WellCare pays the pharmacies.

DR. WARFORD: And you've matched those two sides? I mean, you have data showing that what was sent to WellCare was passed

through? I mean, we have tangible data showing that those numbers are equal?

COMMISSIONER STECKEL: Maybe not yet but we will. And I don't mean to be flip about it. So, there are several questions that came up with this data.

One is the MLR, how is the MLR allocated, especially for the spread pricing? Do they allocate the difference between administrative costs and medical costs properly into the MLR of the MCO? So, that's one issue.

The issue with WellCare is how much were their administrative costs versus their medical costs? So, we're working with WellCare in trying to get to a better understanding of how that works. So, they're being very helpful, very cooperative, but they did provide the information. It's just with the pass-thru, it's a different methodology than the spread pricing.

DR. WARFORD: Understood, but do you understand what I'm saying as well?

COMMISSIONER STECKEL: I do.

DR. WARFORD: I would hope that the State will look at the actual contract as well to see that originally when that was re-signed two years

ago or whenever it was, that the actual rate that they're withholding on the pass-thru is actually what they're withholding and not something different.

And that's information that as a taxpayer and a pharmacy owner, I would want to make sure that that's the case because I've seen plenty of cases in self-funded employers that I work with directly that that's not the case.

I know we're trying to do things that are beneficial here, but my friend actually was the one that owned the pharmacy that closed on Thursday and he has multiple other ones and he's a good business guy. He's very efficient.

And pharmacies are closing while we're just kind of sitting around, well, we hope to get more information. We hope to get more data. We hope to get this. I have colleagues that are closing their doors on reimbursement.

So, the urgency doesn't seem to be there while the pharmacy once again kind of takes the back seat on this. That's my concern. Thank you.

COMMISSIONER STECKEL: Well, and I appreciate that concern, and I'm sorry it feels like we're not taking this seriously but I promise

you we are. It is getting a lot of attention and we are doing as much as we can with what we have.

Now I've lost my train of thought which is probably part of the problem but we are trying to get that information. We do have the unredacted PBM contracts. So, we're able to look at those.

So, we are working on it. We are aware that pharmacies are closing and that's one of the reasons why we wanted to get into the pharmacies and look at the post-payment adjustments to see what they are.

We are moving forward on our recommendations. I don't know what more to say. I can't change Medicaid policy overnight. I have to go through the policy attributed to us by the Legislature and the administrative procedures.

DR. FRANCIS: Hey, Rob, this is Suzi. As a pharmacy owner and specifically in relation to your question here, is there something that when DMS meets with the individual pharmacy owners that you would suggest them looking at or questions to ask specifically in regard to that topic maybe that would help Commissioner Steckel understand your questioning?

DR. WARFORD: Sure. I think there has to be a foundational component on the data that's coming in first and you have to understand what that means to make sure that it's specific to the contract that's been signed. I mean, that has to be first and foremost before you go in and look up the back-end on payments because if you're comparing apples and oranges, it doesn't matter. It's just a shell game.

So, you have to make sure the foundational component is correct before you go in and look at the inside as far as reimbursement goes.

When I just heard PBM's moving into the MCO world and we've seen that before and that's watching Caremark to do that so they wouldn't have basically (inaudible).

MS. HUGHES: Rob, hold on a minute. You're cutting in and out just a little bit.

DR. WARFORD: Okay. Sorry. But my point would be that we have to make sure the data comes in and we understand what that data is. That's first before you start looking at reimbursement. You have to know what's coming in. You have to make sure that that lines up contractually and that makes sense before you go in

and look at pharmacy.

And I can get as many pharmacies as you want to go in and look at them. We have access to hundreds of them in the state. So, we could look at it geographically, demographically, however you want to do it once you understand what you're looking at.

But my only point is when I hear MCOs bringing in PBM's, that definitely does not sound like more transparency as a business owner. So, that scares me when I hear that.

So, that's all I'm saying and I appreciate your effort on this. That's all.

DR. FRANCIS: I think President Palutis has something to say.

MR. PALUTIS: I do, if I could just ask a question maybe to Commissioner Steckel and, Rob, you as well, and I appreciate you saying what you said, but would it be unrealistic to Rob if you would reach out to the person who you said is the employer who is providing the benefit for their employee and the pharmacy who can have clean data and just match them up?

If WellCare says they paid $100 to the pharmacy, look at the pharmacy's claim for

that prescription. Did the employer get charged more or less what--I mean, Rob, if I understood you right, you said you have people who are being charged differently but does that have to do with Medicaid? I'm not really sure. So, that's something different.

COMMISSIONER STECKEL: You lost me on that. That may be the Medicare Advantage Programs.

MR. PALUTIS: Yes. I think we're comparing two things that are not--we're dealing with Medicaid. I'm sorry.

COMMISSIONER STECKEL: But I think, though, Rob, you have a very good point for us to take to heart and that is looking at the contract. What does the contract call for and, then, how does that translate into the independent--into the--and when I say independent pharmacist, into the pharmacy is what I'm saying. So, it could be a retail, but I think you're exactly right on that.

For those of us, many of us in this room that have been dealing with health care for many, many, many years, the evolution of health care is always going to be and will continue to be it's just trying to stay ahead of it and make sure and that's why it's on our radar screen is that as PBM's

move into managed care companies, what does that mean? Start asking the questions now, make sure that when we have a new contract, it allows us to have more information than we're allowed to have now.

So, I can't stop that evolution but I can make sure it's evolving to the benefit of the Medicaid beneficiaries and the people of the Commonwealth as much as I can.

DR. FRANCIS: Okay. So, is there a time frame that you would like to have these meetings?

COMMISSIONER STECKEL: As soon as possible.

DR. FRANCIS: Okay. That sounds good to us.

MR. PALUTIS: I'm sorry, but I have one other question about SB 5 before we switch gears, and I'm sorry to keep talking but it's a pretty big thing that's happening.

So, there's a lot of discussion around the spread pricing that was flushed out in the data. And the one question that keeps coming up and I think I know the answer to but I'm not sure - that's why I'm asking the question - the 1.4 or so billion that was paid, that's the starting point of

those slides and, then, it flushes out the spread pricing, is that the only amount of money that's paid to the MCOs in order to be given to the PBM's or is there like an additional administrative fee?

COMMISSIONER STECKEL: That's it.

MR. PALUTIS: That's it. So, the spread pricing essentially is everything that the PBM might keep over and above the fees paid to the pharmacies.

COMMISSIONER STECKEL: Correct, the $123 million for 2018. And, so, our next step is to flush out what did we buy with that $123 million. Did we buy $23 million worth of profit and $100 million worth of services, and was that $100 million $50 million administrative and $50 million utilization, MAT, other things like that and that's what we're looking at now.

MR. PALUTIS: Thank you.

COMMISSIONER STECKEL: And I apologize. I know it seems like we're going slow, but I promise you we've got resources assigned to this, and it bothers me personally as much.

And I know I don't run a pharmacy, so, I don't have at-risk dollars or

emotions, but this has been an issue that's been near and dear to my heart for a very long time. And, so, I am just as eager for us to get this under control as you all are.

Tell me what I'm not doing that I could do. You sighed and you rolled your eyes.

MS. MILLER: Oh, no, I didn't roll my eyes, no. No, no, no, not at you, no.

COMMISSIONER STECKEL: I don't mean to call you out.

MS. MILLER: No. I didn't mean to. No, it wasn't that at all. It's just out here and we're in the battlefield and we're trying to serve the patients and we see it every day. And like we're all saying, I don't know how much longer we can do it, and I think that's what Rob is trying to say is there's lots of people on edge. So, no, I was not rolling my eyes.

COMMISSIONER STECKEL: Okay. I promise you we're trying.

MS. MILLER: I believe you. I believe you.

MR. PALUTIS: Commissioner, from KPhA's perspective, I want to sincerely want to thank you for the movement that we've had already.

Compared to what we were dealing with in the past, and I'm going to say it even though I'm in the building, but this is like a completely different feeling. And the fact that we're invited to the table and the fact that we're having these open and honest discussions, we can't ask for anything more than that.

And, trust me, we all understand. I was in the corporate world before I opened my own pharmacies. I knew what they were going to send you and they sent you exactly what I thought they would send you which was kind of impossible to evaluate, right?

COMMISSIONER STECKEL: Yes.

MR. PALUTIS: So, I think with the information you've been given, I'm not sure people could ask for much more. I completely and respectfully appreciate that.

COMMISSIONER STECKEL: Thank you and we will continue with all the resources that we can throw at this. The good news is very few state Medicaid agencies have people like Jessin Joseph, like Doug, like Michael Schultze with the data analytic group that really can dig into this and know what to ask for and know how to ask for it.

So, we're very, very fortunate with that and it's just a matter of working through a Gordian Knot that was tied long before many of us were at this table.

MR. PALUTIS: Absolutely.

COMMISSIONER STECKEL: But if you have suggestions. And I'm not being trite. This is something that's going to take all of us and it's going to take being frustrated and it's going to take figuring it out and then it changing and figuring that out.

So, we are very open to suggestions, and whatever we can do together to solve these problems.

One of the data points that we've pointed out in all of our presentations is one of the surprise data points, if you look at the number of prescriptions filled for retail versus independent, they're almost equal, almost equal which the assumption would be that the retail pharmacies fill more. Not in Kentucky.

DR. FRANCIS: Not in Kentucky. I completely echo what President Palutis said. I feel your heart in this. So, we're thankful for that. If anybody had the answer, I think we would

have presented it by now but at least we can investigate because I think we all want the same thing here at this table. Okay.

COMMISSIONER STECKEL: Okay. The 1115 Waiver. We are gearing up for an April 1st implementation. We are waiving the premium for April, so, no one will get a premium invoice in April.

The Judge is allegedly going to rule this week, maybe next week or maybe the day before April 1st or maybe April 1st or maybe April 30th. So, that is the unknown is what the Judge will do.

Because of what happened apparently in July and the horrible snafues that happened in July, we've learned a lot. And, so, we are contingency planning, thus, the no invoices in April.

The community engagement component will start in July. So, that is also being put off. Other than that, what other questions do you have about the 1115 Waiver, about Kentucky HEALTH?

DR. FRANCIS: I did receive Sharley's email about the monthly updates and I sent

it to all of the pharmacy TAC members.

MS. HUGHES: The Pulse newsletter.

COMMISSIONER STECKEL: Okay. Good. Good.

DR. FRANCIS: So, we can sign up for that. Will that be communicated? Is that something we should send out to all pharmacy members to essentially sign up because we'll not have any updates for pharmacists or providers throughout the state in regards to----

MS. HUGHES: Leading up to July 1, they were actually sending that out like every Friday. So, I don't know if they're going to gear up to send it out more often or not but anybody can sign up for it and it automatically comes to whatever email address that you give.

DR. FRANCIS: I was just wondering if that would be a good thing to--you know, we were talking about how should pharmacists notify their patients about copays or other things. Would this be a good communication?

COMMISSIONER STECKEL: Yes.

MS. HUGHES: I mean, any communication that you receive I think is probably

good communication. So, if it's something they can get and not have to depend on--I mean, I try to send that out to the MAC and the TACs every time I get it, but, then, you're dependent upon somebody else sending it on to them. So, if they can sign up for it.

Like this time, they talked about some new documents they're going to be creating and putting on the website. That usually tells them when they're out there, so, if there's a new document or a new webinar or if they're having webinars.

I don't know if you noticed in there, there are some webinars listed on the right-hand side that you could sign up for.

DR. FRANCIS: I noticed after I signed up for it, maybe this was just - I don't know if anybody else did also - all of the categories that you could pick from as far as alerts that you want to. If there's ones that you would suggest that pharmacists pick from, then----

MS. HUGHES: I signed up to receive it so long ago, I don't remember all of the alerts that come out. I think you get all communications that comes from CHFS. So, you might end up getting some stuff that doesn't impact you at

all, not on that particular newsletter, but I think once you sign up, you might get all of the notifications from CHFS; but that Pulse newsletter will have most of the updates regarding Kentucky HEALTH.

COMMISSIONER STECKEL: And now that we have a Pharmacy Director, we're going to have Jessin do more of the targeted outreach so that if he finds out - not finds out - that sounds too random - but when he knows about various things for pharmacy specific, then, he would be a resource to reach out and say this would be good for your members or this would be good for the TAC or whatever. So, he will be helping get the word out also.

DR. FRANCIS: Okay.

MS. HUGHES: Another thing that Pulse usually lists is the stakeholder meetings. So, if you were interested, if there's one in your area, they're still having those throughout the year. They have them in random areas in the state.

If you are not close by and you want to listen in, they do Facebook Live the stakeholder meetings. If you're on Facebook, you can get notifications when the Cabinet goes live for them. That's usually how I watch them and I usually

learn something new that I did not know before.

COMMISSIONER STECKEL: And they're stored, too. So, if you miss the live session, you can go back and see a recorded session.

MS. HUGHES: Yes, you can. I know everybody is very interested in Kentucky HEALTH and I think it would be beneficial to anybody to sign up to receive that.

DR. FRANCIS: Yes. So, we could help educate pharmacists on that communication option.

MR. GLASPER: Yes.

DR. FRANCIS: Okay. So, we will look forward to April.

COMMISSIONER STECKEL: And it may be that we sit down with the Associations and the Communication Division and see if there's not some targeted efforts that we could do with you all, given your hands-on with our beneficiaries.

MR. GLASPER: Yes, we would like that.

MR. PALUTIS: That would be extremely beneficial to really carve out specific items that you really would like the providers to know because everybody has a newsletter, right?

Everybody has information that gets sent out.

And I think that if there's targeted things that could be done in like a bullet point fashion, I can tell you pharmacists would love to have that information come directly through you all so that they don't have to go and hunt it down the reasons why certain things are happening and it would make it a lot easier to explain to patients if we had the actual reasons why instead of us trying to figure it out.

COMMISSIONER STECKEL: Okay. That's a good idea. So, we'll do that.

And I have to admit, the immunization, I don't know the answers to those.

DR. FRANCIS: I did receive an email back from Leeta about the edits that were needed in the chart, just some clinical information and updates that needed to be clarified in there, but she said she would work on it when I was preparing this agenda.

I haven't heard back from her since then but I'll follow up and make sure we get that clarified because I haven't sent that out to pharmacists statewide because there were some things to me that clinically needed to be cleared up.

MS. HUGHES: I did talk to Jessin yesterday for a few minutes and he said he has looked at it himself but obviously he's been busy with the Senate Bill 5 report and a lot of other stuff with us not having a Pharmacy Director for a little while, but he is working on it.

And he said if there was anything else you all needed, I printed it out to bring today.

DR. FRANCIS: I wasn't sure who all was on that email response that I sent out but just to let everyone in the room know. In response to Dr. Liu's mandate, I guess, that MCOs cover immunizations nine and above under pharmacy benefits, there was a chart that DMS owns, I guess, and had prepared but there were some things on it like Zostar Live was on there twice instead of Zostavax and Shingrix where it was recombinant. There wasn't clarification with I think Twinrix, Hep A, B, Combo and I listed it out. The meningococcal vaccines, there wasn't a clarification between the two.

So, just some clinical type of things that I know that our pharmacists will have questions about and that was just all I had to ask to clarify.

MS. HUGHES: He had said that they just used the old format and just updated it based upon the old format. So, they didn't go back in and add more stuff but they are looking at it and they're trying to get it ready for you.

DR. FRANCIS: Okay. And anything I can do to help, let me know.

COMMISSIONER STECKEL: Perfect, and that's the benefit of the TACs is helping us look through these things and make sure that we're being accurate and correct before we send them out to the full membership. So, thank you very much.

DR. FRANCIS: I can even redo the chart, just edit it as needed and, then, everybody could say covered, not covered, whatever. So, however I can help with that. I just would like to get it out there because I do think that it will help benefit our immunization rates.

COMMISSIONER STECKEL: Perfect. The other thing, too, and this isn't on the agenda but we are beefing up the Pharmacy Department.

I know this doesn't sound like a lot but in addition to two pharmacists, Leeta and Kasie, we're bringing on one other person, kind of a high-level project manager, certified project

manager. So, that will be another person that will be able to help us get organized in that Department. It doesn't sound like a whole lot, but in state government, one senior level person is pretty good.

So, we're excited and we're thrilled with the work between our organizations and what we're able to do. I know it's not fast enough, it's not thorough enough but we will get there.

So, that's all I have, Madam Chair.

DR. FRANCIS: And the last thing was just the options and I know that Shannon Stiglace had brought this up at the last meeting but it is a valid option because a lot of times, physician offices may not carry a certain vaccine and a child less than the age of nine needs it. A pharmacy carries it. In Kentucky, it is able to be administered by a pharmacist at a pharmacy with a prescription under the age of nine; but according to our chart, it's not covered.

I don't know if there is a prior authorization that could be put in place or something that says, hey, this is via a prescription, but it at least allows that option and I think it has come into play recently with immunization changes for

school and Hepatitis A.

COMMISSIONER STECKEL: Okay. Let me get with Jessin about that.

DR. FRANCIS: Okay.

COMMISSIONER STECKEL: And we did lift the PA on twenty - I keep getting this wrong - twenty-four or twenty-six milligrams of Buprenorphine.

MS. HUGHES: I think it's twenty-four.

DR. FRANCIS: Twenty-four.

COMMISSIONER STECKEL: I think so, too. I've been corrected a couple of times. You should have gotten notification about that. I know the health plans have.

And lots and lots going on with the Legislature. We added up all the bills two weeks ago that affect Medicaid and it's $1.4 billion unbudgeted. They have since started taking things off the agenda and we're down to a little under $800 million unbudgeted. So, if anyone thinks that we're going to have a fun budget year next year, I would remind you of that number.

DR. FRANCIS: Okay. Just for you, I think April Cox from Aetna came in to the

room, Director of Pharmacy for Aetna, and, then, Joe Vennari from Humana-CareSource.

COMMISSIONER STECKEL: So, any questions or anything else?

DR. FRANCIS: I think we got at least two take-aways for KPhA. Thank you, Mark, and we'll work on that. Of course, to me, that's a high priority is Senate Bill 5 and helping you understand that because it affects our businesses, our pharmacists, our patients and the ability to move forward with improving patient outcomes from there.

So, the sooner we can figure that out, the better I think for all of us.

Let's go around with the MCOs if there's anything. Aetna, April, if you're ready.

DR. COX: So, we went live with the PA removal for Buprenorphine officially effective February 26th but we did backdate to coincide with the State recommendation, so, we are live with that.

We are wrapping up the FPL indicator with our PBM. They're completing coding expected by mid-March. So, I would say maybe third, early fourth week of March, we should have that completed as well.

I think at our last TAC

meeting, I mentioned that we had just started with the CPESN Pharmacy Network and that's going extremely well. We went live with them on January 1st. We have six pharmacies in Western Kentucky they we're partnered with to provide care management and care plans for some of their members.

So, we identify the members and send those members to the pharmacies and they do outreach, face-to-face consultations. These pharmacies actually also deliver medications to the member's home. And, so, they're also able to identify any areas where the member may need assistance with transportation, food, anything like that. So, it goes outside of pharmacy to cover the patient as a whole.

We've had some great success stories already just in the first two months of the life of this program. So, I'm really excited about it.

DR. FRANCIS: On your second point, this is just probably my lack of knowledge, what is FPO indicator?

DR. COX: The Federal Poverty Level----

DR. FRANCIS: Okay, FPL.

DR. COX: ----so that pharmacies will be able to know if a member or a patient is at, above or below and then that goes to the whole whether or not you can waive a copay on those members.

DR. FRANCIS: Okay.

COMMISSIONER STECKEL: You can't waive a copay. You have to absorb the copay or you could turn the patient away.

DR. FRANCIS: It depends on the FPL level.

COMMISSIONER STECKEL: If they're over 100% of the Federal Poverty Level, you can make a decision to provide that service or not if they refuse to pay the copay. If it's under 100%, you have to provide that service.

DR. VENNARI: It's 100 or below, correct?

COMMISSIONER STECKEL: Correct.

DR. VENNARI: So, 100 or below, you cannot deny the service. It's like less than or equal to.

COMMISSIONER STECKEL: Yes. I love statisticians.

DR. FRANCIS: That is helpful

to our pharmacists. I know that happens a lot and how are they supposed to know what the patient's income is. So, if there is something so that they can make that decision offhand and have a clinical judgment probably, too, if this is something necessary, of course.

DR. ROGERS: Suzi, if I could ask. What would be helpful for pharmacists to understand that? So, we're going to be sending over an indicator that will tell you whether they're at or below or below; but if you see that, what additional information do you think would be helpful?

DR. FRANCIS: I think just that exact wording almost. I don't know what your indicator looks like.

DR. VENNARI: It will come across in the text field.

DR. FRANCIS: Like the edit?

DR. VENNARI: It will come across in like a message field.

DR. FRANCIS: Like the adjudication edit?

DR. VENNARI: Right, but we still have to send a copay. The copay will still be there. So, it will come across on the text field.

So, you have to look in your messages.

DR. FRANCIS: So, it might say $2 and, then, right under that say patient is----

DR. VENNARI: Patient is at or below 100 FPL or over 100, yes.

DR. ROGERS: Because we have limited characters for the messaging----

DR. VENNARI: Yes, like forty.

DR. ROGERS: ----but we want to make sure we provide messaging that's clear for you to know what action to take.

DR. FRANCIS: I think we could communicate out what that means and that it would come across in a text format with the copay. If there's only forty characters or so, less than or equal to Federal Poverty Level or greater than and, then, we could educate on that. Of course, it would be wonderful to say greater than Federal Poverty Level, must collect copay.

COMMISSIONER STECKEL: Well, you must collect the copay, period. Now, the difference is if they refuse to pay the copay, then, it's if you're 100% or below----

DR. FRANCIS: You must provide the service.

COMMISSIONER STECKEL: ----you must provide the service and absorb the copay. If it's over 100%, then, you can refuse to provide the service.

DR. FRANCIS: And that's gut-wrenching for our pharmacists a lot of times. I've been in that situation myself and you're talking about $2 or $4 but it happens a lot and you don't want to break any law or anything. So, I think anything we can do to take that off of a pharmacist or explain that better would be very helpful.

DR. VENNARI: The message that's going to come across that we have set up is member is at or below 100% FPL.

COMMISSIONER STECKEL: Which means you have to provide the service.

MR. PALUTIS: Is there a way to have standardization across the MCOs so it says the same thing?

My concern also is you might send it out a certain way. How does that translate through NCPDP and then up in the pharmacy's software's computer system and what does that message say because we all know that sometimes it doesn't always--it depends on the pharmacy's providers and

the way you intend it when you send it out.

DR. ROGERS: That's my concern as well, yes.

DR. VENNARI: From what I understand is on the Kroger system, from what I understand is the message doesn't come back on the field, on the front field. They have to go into a back door. In fact, they would have to go to another screen to actually see the messaging.

So, that is something that they will have to call the vendor with and move that forward or move some sort of indicator forward or they will have to do that for every Medicaid patient is to check that additional page.

DR. FRANCIS: Right, right, or if it's below the FPL, then, they could have some kind of hard stop in their electronic computer system or something that would be labeled.

DR. VENNARI: Well, it would have to read the message, though, in order to--it would have to read a text field in order for that to happen. So, that's a lot more complicated logic, I would think, if you want to build a hard stop on that end.

I think it would be easier to kind of move that message to your front screen and have like a marque or something for you. Do you know what I mean? That would be an easier fix than having it scan every message field and hard stop it.

DR. COX: My previous experience is with Walgreens, so, I know how their system works, but like if there's a messaging for Kroger and it says prior authorization required, is that on the front or do they have to go looking for that, too?

DR. FRANCIS: That would stop them and it wouldn't adjudicate the claim.

DR. VENNARI: That's hard-coded.

DR. FRANCIS: But this would go through regardless with a $2 copay and, then, you would go searching for it. It's just like if a patient questions a deductible or something, you would have to go back.

DR. COX: What about the soft edits that are over-rideable at point-of-sale?

DR. FRANCIS: Sometimes they'll stop and, then, you would provide an override ability or so, but I don't know that you would want to get a

soft edit for every Medicaid prescription.

MR. PALUTIS: I think I have a feeling. It depends on the software provider because you could get a paid claim and still get the message from the PBM or the MCO or whoever is the originator of that message and it comes up in the paid claim and you can read it and, then, there's other messages that come up below it and, then, there's a screen that you go into behind it. Some even send you what their annual deductible is and you can find that information. You have to go hunt for it but----

DR. FRANCIS: It's different.

MR. PALUTIS: I think everybody's systems work differently and how that communicates down is going to be a challenge as to what system you ultimately have.

MS. HUGHES: Does the pharmacist have access to KYHEALTH.Net?

DR. VENNARI: They do from what I understand. Do they have MMIS, too? I think the reason why we went down this route is because it's just too clumsy to ask the pharmacist to go in and look every single time.

MS. HUGHES: Okay.

MS. MILLER: It is. It's very

hard to navigate that site. I get on it a lot. It's very hard.

DR. VENNARI: They'll spend too much time doing that. So, at least if we can get the message out to them, so, all they need to do is - all they need to do - is get that message to come to the forefront. And, so, they have to probably work with their vendor or whoever to make that happen if it doesn't already come back on your return screen as it is now.

DR. ROGERS: And I know we're all probably going to be working on communications around this and I appreciate your comment. Maybe something we can collectively look at is how we make it more user-friendly.

DR. VENNARI: It really should be a standardized message, I think.

MR. PALUTIS: And if it's standardized, then, we could help get the word out by saying, look, you're going to see this message somewhere in your adjudication screen. Find it because it should be there----

DR. FRANCIS: Or even what it means.

MR. PALUTIS: ---and here's

what it means. And if we could all agree to have the same message, it's easier to disseminate out to the providers that says find this message and here's what it means.

DR. FRANCIS: And that would be something the MCOs could do. It would be very helpful to do. I believe step one is having that standard message, something we can educate out and, then, step two is how to make it user-friendly.

MS. HUGHES: I'll let Jessin know to see if he can work with the MCOs and PBM's to get a standard message.

DR. ROGERS: I have reached out to Jessin to ask what they were using so that perhaps we could model that but I know he's looking into that.

DR. FRANCIS: Great. Okay. So, I think Anthem.

DR. RUDD: I basically echo everything that Aetna had to say. We removed the PA on Suboxone, Buprenorphine products on the 15th, and those claims have been processing without PA. I haven't been notified of any problems with that. So, that's really the only thing that I have.

DR. FRANCIS: And is that

greater than twenty-four milligrams for all length of time or all Buprenorphine or educate me on that?

DR. RUDD: So, it's each MCO's preferred product. So, for Anthem, it's the generic tablet product. And, so, it's up to twenty-four milligrams without prior authorization.

DR. FRANCIS: Okay.

MR. PALUTIS: But I think you're asking for is there a time for----

DR. FRANCIS: Is there a thirty-day supply, less than twenty-four----

MR. PALUTIS: Like, could somebody get a ninety-day supply?

DR. ROGERS: No. It's the standard benefit supply, so, thirty days, thirty-one days.

DR. FRANCIS: And we still have the fourteen-day emergency supply.

DR. ROGERS: For pregnancy. So, those ICD-10 codes will allow the mono product to go through.

DR. FRANCIS: Okay. So, less than or equal to twenty-four milligrams per day without a PA, okay, and, then, standard for pregnancy, mono products. Anything else?

DR. RUDD: No.

DR. FRANCIS: Joe?

DR. VENNARI: Again, echoing the same statements that these folks have said except that the twenty-four milligram would be--I mean, we have the fourteen-day that's already in but the twenty-four milligram should be by the end of this week, if not already.

DR. FRANCIS: Okay. Passport.

DR. ARMSTRONG: Same thing. We've got the coding in for our preferred product which is the Buprenorphine/Naloxone tabs up to twenty-four milligrams, and we still have the bridge coding piece for the mono product for pregnancy.

DR. FRANCIS: So, if they do get a PA, it might just not be the preferred product like the films or something.

DR. ARMSTRONG: Correct. We still have the prior auth on the non-preferred products.

DR. FRANCIS: Has all of this been sent out in some way already to pharmacies that we could reiterate?

DR. ROGERS: It happened so fast that we were trying to get the coding together.

DR. RUDD: There was message that was sent for approval for prescriber notification but I don't think anything was sent out to pharmacy.

MR. PALUTIS: Well, I can tell you the pharmacists would love just filling a claim and not having it reject.

DR. FRANCIS: I think they're going to know----

MR. PALUTIS: They're going to figure some things out.

DR. FRANCIS: ----but at least we can say standard MCO wide, it should be less than or equal to twenty-four milligrams per day of preferred product. So, if they go searching for a PA, it might not be a PA they need. They just need to actually switch the product.

DR. ROGERS: Right. That's a great point there because I think there may be some confusion on what the preferred products are.

DR. FRANCIS: And really that's important for delayed treatment.

MR. PALUTIS: That's something, Mark, we need to send that out. Does every MCO have the same preferred is L tabs. Does anyone prefer the

films? And I know the films now are in generic.

DR. ROGERS: No. Generic----

MR. PALUTIS: Just all tabs. That should make it easier.

COMMISSIONER STECKEL: And this was a case where we actually were able to do something quickly. We talked to a physician at a UK clinic that testified about 100 pages of information she had to send in to our lovely MCOs for a PA.

And, so, when we talked to her and walked through what all was happening and then talked to Dr. Liu, we literally made the decision that day.

And, so, when the MCOs say that they're trying to get--I mean, it caught everybody by surprise but we were able to get it done.

DR. FRANCIS: That is great because we don't realize the downstream effects that that has. Only 20% of people are able to get off that in treatment and function, but they can live functionable lives on treatment with that and a lot of medication-assisted times, and, so, removing that red tape really helps a lot.

I know it's expensive. I know that there's warnings of abuse, but in most cases,

that's what you need for treatment.

COMMISSIONER STECKEL: And as you can imagine or maybe not because you're not familiar with the Medicaid Program, but we're very cynical. So, we've already fired up our Program Integrity to start watching the data. And if we start seeing anomalies in the data, then, we'll start doing some investigations.

MR. PALUTIS: If the claims go up by 25%.

COMMISSIONER STECKEL: In one area, right, exactly. You got it.

DR. FRANCIS: Okay. Thank you for that. WellCare, anything?

DR. ROGERS: Oh, gosh, I don't have anything to add. Everything everyone has said.

DR. FRANCIS: PTAC members, anything?

MS. GRAY: No.

MS. MILLER: No.

DR. FRANCIS: Let's move on if we didn't have anything back there because I know I have something later on it.

Following up on previous agenda items, so, potential pilot programs to improve

outcomes. April had kind of mentioned this. I'd like to learn more about results, more about the program details and then potential results just so we can all understand how we're working to actually effect patient outcomes through one of the MCOs.

So, I don't know when a good time might be for that, at our next meeting, if you might have anything to share then.

DR. COX: At least give me because we're slowly collecting data because we just started in January.

DR. FRANCIS: Okay.

DR. COX: If you could give me until maybe at some point during the second quarter, I think I would have some data to share. That would be helpful.

DR. FRANCIS: And our next meeting would be May. And even if there's just some----

DR. COX: I may have some preliminary that I could share.

DR. FRANCIS: Maybe not even results but just how the program is structured would be helpful.

DR. COX: Definitely. And I

can give a little information on it now if you want.

So, basically, with our six pharmacies that we have, two of them are actually the same pharmacy. They just have two locations. So, technically it's five.

When we identify the members, we're looking at their pharmacy claims obviously. So, we're looking at polypharmacy, so, members that are on multiple medications.

The goal of the program is not necessarily de-prescribing. I know that's a big initiative now, getting people off medication. That could be the case for a particular person, but it's also identifying care gaps.

So, this person may be on eight medications but do they have a controller medication for their asthma; are they on a statin since they have diabetes, those types of things. So, we're also looking at care gaps.

So, the pharmacists are providing complete medication histories on the member. They are identifying these care gaps if they exist. They're looking at their immunizations, making recommendations if they need to get their shingles vaccine or their pneumonia vaccine.

They're contacting the prescriber with the recommendations and saying Prescriber X, this patient has not been filling their statin for "x" amount of time. Do we need to get labs ordered? I can take care of that in my pharmacy, you know, whatever they can do to help assist the medical provider.

So, they are providing this care plan with all the information to us with what they found, whether it's polypharmacy, missing medications, social determinants of health that need to be addressed. They're providing all that information to us.

So, we have myself, I now have a clinical pharmacist at my plan as well and, then, our case managers are partnering all together. So, the reports come in to the case manager. We have one assigned at our plan. She reviews them all.

They can refer members to case management. They can say we feel this member would be a good person for case management for "x" reason. And, so, she will take that and take initiative to outreach to the member and identify or work with them on whatever issues they have that we can resolve at plan level.

From the store level option, they're making their recommendations to the provider. Then they will send another care plan in once the provider responds to let us know if, yes, the doctor agreed with our recommendation, no, they didn't and what changes were made or if any changes were made at all.

From my perspective, from a pharmacy operations' perspective, for example, we had a member that was on a Humalog insulin. So, we recently moved our preferred insulin to Admelog and notified our members and providers as we are supposed to, but this particular member is visually-impaired.

And, so, he was having a hard time drawing up his insulin from his vial and his blood sugars were all over the place. So, initially, it looked like he just possibly wasn't taking his medication but that actually wasn't the case. He was taking it. He was drawing up the dose incorrectly.

So, we have weekly meetings with the CPESN group to review the care plans. So, when this particular care plan was being reviewed, they were talking about the insulin. Well, the first thing that came to mind, oh, we need to get him switched because his insulin is no longer going to be

on Formulary. I don't want him to go without the medication. We took care of that immediately. But when they brought up the whole visual impairment, I knew he was going to need a pen and that would possibly help with his insulin dosing.

So, I went ahead and provided an authorization for him. The provider was able to bypass the PA and process completely, got that override in the same day. The member was able to get his pen and now we're waiting on a care plan to come back to let us know if his blood sugars are looking a little bit better, if this was helpful to him or not.

So, that's just a quick example of what we're seeing. And from a plan perspective or even from a case management perspective, some of these things you can't see.

And having personally been a retail pharmacist, members trust their pharmacist and the pharmacist at the store level, you're the first person they see. They're going to come to you more than they go to their doctor. So, you can see things that we as an MCO may not be able to see.

We've even had a member where they were already in case management and some of the questions that were asked by the case manager, their

response was, no, no issues there, no issues there, no issues there.

When the delivery driver went in to the home, actually most of those answers were yes, yes, yes, yes. We had no idea because they have a relationship with their pharmacy. There's that trust there; whereas, with a case manager, possibly they didn't feel as comfortable. So, they were able to report that back to us in a care plan.

And, so, we are also developing care packages that we can send out to the pharmacies to be delivered to the members when their medication is delivered.

So, we're working with them to identify different items we can put in these care packages. So, it can be toiletries, food, scarves, hats, gloves, whatever they may identify that this member may need. So, we're developing care packages that they can use.

So, again, it goes outside of just drugs and pharmacy. We're just trying to look at the member holistically.

DR. FRANCIS: That's great and I'm so happy to hear you say that there's things that you--we're all pharmacists, right, and we know that

there's things that you just can't capture with a phone call from a central pharmacist that someone face-to-face catches.

So, my, then, initial question is how do you turn back because that takes time on that pharmacist and, then, how do you turn back in and the improved outcomes you have on that patient, how is that pharmacist compensated?

DR. COX: So, we do have a contract and they are being reimbursed. We have a contract with CPESN. And, so, the way we have it set up, we are doing monthly invoices based on care plans and they are compensated for joining the program and then per member that they see.

DR. FRANCIS: Is it based on member risk level or anything or is it just per member?

DR. COX: It's a flat fee. Per member per month.

MS. MILLER: I'm a member of the CPESN organization and we're piloting a smoking cessation project in Northern Kentucky, and I'd love to have some of the MCOs that want to hear about it trying to develop a relationship so we can be paid for counseling for smoking cessation.

I think that's part of the requirements in Kentucky but we don't have the mechanism to bill for it. So, if anyone is able to give me any feedback from the MCO side about how we can apply to be reimbursed. This is a pilot with the Health Department in Northern Kentucky trying to reduce smoking rates in Covington which their rates are about 38%.

MS. COX: And that's one of the things I know we've been talking back and forth that doesn't exist right now on how to bill for something like that from a pharmacy perspective. So, we do have discussions going on at our plan to try to identify how we can make this happen.

MS. MILLER: And it's slow.

MS. COX: And it's slow but discussions are occurring.

DR. FRANCIS: So, that leads me to my next couple of bullet points here.

MR. PALUTIS: Suzi, could I ask just a couple of questions?

DR. FRANCIS: Yes.

MR. PALUTIS: I'm really happy to hear that that's happening, and these are just operational questions.

From an operational standpoint, do you all provide a platform for the pharmacy to go in? For example, does the pharmacy go in and if you select Patient A that you want to put on the program, does the pharmacy have the ability to tap into your system to automatically know if they're a polypharmacy patient or is everything still all manual?

DR. COX: Yes. So, that's why we're identifying the members for them since I have all of their pharmacy claims that have been processed through the PBM. So, that's part of the reason why we're identifying the members for them.

So, we're looking specifically at their pharmacies, members that meet ABC criteria. And, again, we have one case manager, two pharmacists that are working on this internally at our plan.

And, so, we're trying to start off kind of small with these six pharmacies. So, initially, we sent each pharmacy five to six members to look at and we are developing the process of how long we'll keep these cases open.

We're currently looking at the second group of members to send them but we're trying

to keep it small at this point because they can't tap into our database. So, it's manual on our end and then we have to send it to them.

MS. HUGHES: Can I ask a stupid question? What is polypharmacy?

MR. PALUTIS: It's when a patient goes to multiple pharmacies instead of just one.

DR. FRANCIS: Or is on multiple medications, too. There's a couple of different terms. Typically when a provider talks in that way, it's usually that they're on multiple amounts of meds. Pharmacists I think are trained in the multiple kind of pharmacy----

MS. HUGHES: I kind of thought that was what it was.

MR. PALUTIS: You know what would be good is when you came back and shared all the data, maybe bring one of the pharmacists so that they can talk about----

DR. FRANCIS: Their experience with the program, absolutely. That's a great point.

DR. VENNARI: Are you looking at diagnosis and how many scripts they have, like a set number, like ten or more or eight or more?

DR. COX: So, I believe they're looking at I want to say ten is what we're looking at right now and, of course, it's evolving. So, if we start noticing, well, actually, we don't have as many people as we thought that go to your pharmacies with ten or more, then, we would lower it down a little bit.

So, we're kind of just playing around with it right now trying to get our bearings, but I think that number right now is ten.

DR. FRANCIS: That's probably good. Most literature shows eight to twelve scripts.

DR. BETZ: April, how are your pharmacists contacting the providers? Are they actually calling them?

DR. COX: So, it can be whatever point of method they choose. So, some will fax. Some will call and leave a message.

DR. BETZ: It would be interesting in your project if you're not already looking at it to look at the means of contact in terms of your level of success.

As somebody who is married to a family physician, the amount of faxes that come through on a daily basis and probably who that

trickles down to as opposed to a phone call to the provider, although obviously it's going to take more time to track them down. It would just be interesting to kind of look and see if you have a different percentage response rate from one versus the other.

MS. MILLER: The platforms, they're trying to provide for direct secure messaging. And I've talked with Suzi about that, like how the physician or provider has to be able to receive it as well and where does it go in their electronic health record but that's being built on the pharmacy platform side.

DR. FRANCIS: We're talking about trying to get at how could it come up directly in Epic like in a message where the provider is more likely to take it serious.

As of right now, I tend to intercept a lot of those and to explain it to the provider this isn't just some random fax you're receiving. This is a true patient care need. That's a big need.

DR. BETZ: I think with an Epic, it will work out really well.

DR. FRANCIS: All great things.

When we talk at first level, it's great and, then, there are always barriers to work out as you go down. So, I'm sure that I've encountered most of those barriers in my work somewhere along the way. So, we'd love to discuss it here.

And what I was getting ready to say is that's why I requested a meeting with you, too, is in addition to our work here, in your request for the Pharmacy TAC to help improve outcomes from a pharmacist's perspective for members, we're also working as a state organization through KPhA, for lack of a better word, a provider status workgroup but it's really as how can we work out a work flow mechanism to compensate pharmacists for these types of things but yet drive patient outcome improvement.

So, like we said, in the end, it would be cost beneficial or cost neutral, but we want to develop some programs and this is one type of avenue; but we didn't want to start with something that wasn't important to the State, I guess.

So, we wanted to align our missions with what are the top things that the State is looking at? Is it reducing A1c for diabetics? Is it tobacco cessation? Is it obesity? I don't know what it might be - heart disease, COPD.

But if there are certain things that the State is working on, I wanted to kind of know that and, then, we could potentially put into place some workgroups and bring that back I think to the Pharmacy TAC and look at more things like what April is speaking about.

COMMISSIONER STECKEL: And that would be good because we're redoing our statewide quality plan in conjunction with our RFP for the MCOs.

And one of the things that we want to do is instead of the rifle shot of fifty different quality measures, we want to focus on four or five quality measures for the next three years, with the idea that if all of us, both the fee-for-service, all of the managed care organizations, all the providers, everyone was focused on these five things, can we move the needle and can we actually, in fact, see outcomes that we're hoping to achieve?

And, so, we're working on that, Dr. Liu and Angie Parker with the MCO office. So, I'll have them there, too, and we can talk some more about it.

DR. FRANCIS: Yes. And I've brought this to this group for at least a year now

probably, but I know it's hard from the MCO standpoint as to what are we allowed to do, what can we do; but if we could really think about what we want from the DMS Corps and then build some things together from there, I think that would be great.

But recognizing our first-hand people are also undergoing such severe labor cuts because of the DIRB's, generic effective rate, everything we just talked about, how can we at least try to show some improvement to say, hey, investment is important? So, I think that was my point there.

Does anybody else have anything on that? And I'm working with Donna on a good time for that meeting.

Any other New Business? One thing I just kind of have is just operational with the Pharmacy TAC meetings.

I know that you said you wanted to have them all here at the Cabinet. I want to make sure that it's easy and communicated well. Mark helped us in the past making sure that everyone was updated, had calendar invites and knew well in advance of when the Pharmacy TAC meetings were.

We're all learning as this is transition. This is the first one here and there was

some that weren't aware until the last minute.

So, I had sent the TAC members just my own invite but I don't know if there's better communication ways or just ways that we can understand that this is where we look for them. I know that you said that they're posted on the website.

MS. HUGHES: Right. And I think the MCOs were all told in January that they needed to watch the website for the TAC meetings, that we were not going to be notifying the MCOs of all the TAC's and meeting changes or times and so forth, that they're all posted out there.

So, if they didn't know about it, then, they just didn't look at the website to see. My goal - I'm trying to get all these TACs organized - is to put me on a calendar reminder for myself. I want to try to send out a meeting notice week in advance to the TAC members. That's what I do for the MAC. Like a week before the MAC, I'll say, hey, guys, don't forget, we've got a MAC meeting coming up. So, I want to do the same with the TACs and just to let the members know to remind them.

If you all want me to send them----

COMMISSIONER STECKEL: No. No. Our responsibility is to invite the TAC and to make sure the TAC knows about it. That's it.

MS. HUGHES: And I'm not sure that my Outlook notice, depending on what calendars you all use, would even allow it to show up on your calendars.

DR. FRANCIS: I guess you and I would work together as we have and I can communicate that out. Is that a problem?

MS. HUGHES: No.

DR. FRANCIS: If your calendar is like mine, it fills up a few months in advance. And, so, I like to make sure that I have that time blocked ahead of time.

COMMISSIONER STECKEL: And our meetings are scheduled for the year. So, the MCOs can look at the website, figure out when the meetings are and know that they're going to be here.

DR. FRANCIS: And if there's any changes, Sharley and I will communicate.

MS. HUGHES: If we change our room or something, yes, we will communicate that out. If there's some reason that at the last minute, for instance, if we had gotten up this morning and there

had been ten inches of snow and we didn't want to travel, I would have communicated that out to the MCOs and to you all as well that the TAC meeting had been cancelled; but other than that, they should check.

And I think I sent even the calendar out to all the TAC members and the MAC members that has every TAC and every MAC meeting listed.

COMMISSIONER STECKEL: And I don't mean to be rude, but there are fourteen TACs and one MAC and we don't have the resources. So, you can decide whether you want us to work on TACs or SB 5 stuff. I don't mean to be rude but----

DR. FRANCIS: I just want to make sure that we're clear on the expectations. Like I said, it's just a time of transition and we were used to doing it in a certain way.

I did take the calendar from last time. If you don't mind just re-sending me the most up-to-date version and I can make sure because I think I had the MAC on the 21st as opposed to the 28th and, then, we'll know exactly where to look for the meetings on the website.

I'm happy to continue sending

meeting invites if that helps you all.

MS. HUGHES: And just for the MCO and for you all - I think I probably mentioned this last time - we do have a website set up for each of the TACs. So, if you're only interested in attending the Pharmacy TAC, all you have to do is go to the Pharmacy TAC website and that gives you all the meetings, the times, the location and everything right there. It's current and up to date.

It's got the TAC members. We're going to start putting the agendas out there. Now we will put the January minutes out there since they have been approved now. And if there's a change, we usually put it across the top in big bold letters, meeting is cancelled or what-have-you so you will know in advance where to come. You also have your own website that you can look at for information that we have here from the meeting also.

DR. FRANCIS: Okay. That's great. And, then, how do the minutes from today come to us to review?

MS. HUGHES: I'll send them to you. Terri is very fast. She normally gets them to us within a week to ten days. I don't know how she does them so quick, especially when we have so many

this month. And as soon as she sends them to me, I will send them out to the TAC members for them to review. And, then, at the next meeting, you can approve them.

DR. FRANCIS: Okay. One thing I would want to also know is if we can have a phone conference line set up ahead of time and maybe have that posted or whatever also.

MS. HUGHES: I will try my best. I'm sorry. I just thought the phone worked.

DR. FRANCIS: That's okay.

MS. HUGHES: I will have our IT folks look at it.

DR. FRANCIS: Okay. One internal Pharmacy TAC thing that we need to do is we did have two members that needed to be nominated. Paula's term and Rob's term had come to a close, and KPhA nominates the members.

And, so, KPhA does have a Board meeting on March 14th and will work to nominate the two members. It may be Paula and Rob again, I don't know, and the KPhA Board will work on that and that will be announced after the 14th.

Mark, anything in addition that I forgot there?

MR. CLASPER: No. You're good.

DR. FRANCIS: Okay. So, Sharley, the next MAC meeting is the 28th.

MS. HUGHES: The 28th at 10:00. The Session is still going on, so, there is a possibility we could be booted out of that room because LRC takes precedence. And, so, we will notify everybody if something changes.

We've never been booted out except for one time in all the times I've been working with the MAC.

DR. FRANCIS: Are those meeting dates aligned with what you have for May, the next Pharmacy TAC, May 21st so, at least we can all pencil it in here? That's what I had on the calendar.

MS. HUGHES: May 21st from 9:30 to 11:30 here in this room.

DR. FRANCIS: And the next MAC meeting is May 23rd?

MS. HUGHES: The fourth Thursday. The 23rd, yes. The easy way on the MAC is that it is always the fourth Thursday except for November because the fourth Thursday is Thanksgiving. We have it on the third.

DR. FRANCIS: Okay. Is there

anything else I forgot today that we needed to cover? I don't think we have any recommendations, but if we could look at those minutes. I don't know if you would like for me to give an update at the MAC meeting on the 28th. I don't think we have any formal recommendations.

MS. HUGHES: I also send the TAC minutes to the MAC ahead of time. If you're there and you want to present and just give a quick update. You certainly have the right to come. Each TAC has the opportunity to present, even if there's no recommendations, to present a little bit of what's going on in the pharmacy world.

DR. FRANCIS: And if schedules wouldn't allow us to have a member there, they would still have the minutes ahead of time that the MAC members would review.

MS. HUGHES: Right. And if there was anything in particular that you wanted to make sure the MAC members were aware of and you could not come, if you email that to me, I can give it to the Chair and she can read it to the MAC members or I can just say the Pharmacy TAC representative is not able to be here today and she wanted me to let you all know this and I could read it for you.

Now, I don't want to read the whole minutes.

DR. FRANCIS: I understand. Okay. I think we can adjourn early, then.

MS. MILLER: So moved.

DR. BETZ: Second.

DR. FRANCIS: We are adjourned.

MEETING ADJOURNED